DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 — 12/09/17/10d 12/27/17

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445358	A. BUILDING _____ B. WING _____	10/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEBRIDGE, A WATERS COMMUNITY, LLC	115 WOODLAWN DRIVE JOHNSON CITY, TN 37604

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F 000	INITIAL COMMENTS An annual Recertification survey and investigation of complaints #41540, #41705, #42484, and #42745 was conducted at Lakebridge, A Waters Community, LLC. Deficiencies were cited related to complaints #42484 and #42745 under 42 CFR 483, Requirements for Long Term Care Facilities.	F 000	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Lakebridge A Waters Community of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Lakebridge A Waters Community files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid Program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal, and any other applicable legal or administrative proceedings. This plan of correction should not be taken as establishing any standard of care and the facility submits that the actions taken by or in response to the survey, findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable in administrative, civil or criminal proceedings.	
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to prevent the misappropriation of medication for one resident (#55) of 3 residents reviewed for medication management.	F 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nyda Bass — TITLE: Administrator — (X6) DATE: 11/20/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OMO511 TN9008

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F 224	Continued From page 1 The findings included: Review of the facility policy, Controlled Substances, dated November 2016, revealed "...b. All...controlled substances...will be counted each shift...both nurses will count the number of packages of controlled substances that are being reconciled during shift to shift count..." Medical record review revealed Resident #55 was admitted to the facility on 11/12/15 with diagnoses including Hypertension, Dementia, and Quadriplegia. Continued medical record review revealed the resident was discharged home on 8/25/17. Review of a controlled medication receipt, dated 8/26/17, revealed the facility had received a 30 count of the medication Alprazolam (anxiety medication), the day after the resident had been discharged. Interview with the Director of Nursing on 10/25/17 at 10:22 AM, in the conference room, revealed the Assistant Director of Nursing (ADON) discovered the empty medication card in the facility's Sharps container (a hard plastic container used to store needles and other sharp instruments safely) on 9/1/17. Continued interview revealed the medications from the card (30 Alprazolam tablets) could not be accounted for. Continued interview with the DON and review of the facility's investigation dated 9/1/17, revealed the charge nurses had failed to count the number of controlled substance cards at the change of shift. Continued interview confirmed the facility's policy for the management of controlled substances had not been followed.	F 224	F224 The Facility will prevent misappropriation of Medication. 11/30/17 **CORRECTIVE ACTIONS:** Resident # 55 was discharged from the Facility on 8/25/17. Pharmacy was notified 9/1/17 and charged the facility for cost of medication. Physician, Responsible Party and Police were notified on 9/1/17. **IDENTIFICATION** Audit of all medication carts and narcotics were conducted by the Director of Nursing and Assistant Director of Nursing on 9/1/17 NO CONCERNS NOTED. 100% audit of all narcotic medication, Narcotic Sheets, Pain Assessments and MARS was completed by Consultant Pharmacist on 9/8/17. No concerns identified. **MEASURES'/SYSTEMIC CHANGES** DON/ADON in-serviced licensed nurses on 9/4/17. Director of Nursing, Assistant Director of Nursing and Nursing Supervisor will audit licensed nursing staff during shift change for proper narcotic count technique and properly stored medication in med carts For 5 days a week then 3x week for 4 weeks then monthly for 3 months to ensure compliance. Negative finding will be addressed immediately and education provided as needed.	

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F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, medical	F 309	MONITOR/QA F224 The Director of Nursing will present findings of audits to the QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance, Social Services Director and other staff as appropriate) monthly for review and recommendations. F309 The Facility will follow the physician's medication order. CORRECTIVE ACTIONS: Director of Nursing reviewed the Physician orders for Resident # 200. Family requested review of discharged meds. Errors were identified upon this review and the responsible party, Veterans Administration and the Medical Director was notified. The Medical Director reviewed the Medication Errors and saw no adverse effects for this resident. No other concerns were noted.	11/30/17 11/30/17

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F 309	Continued From page 3 record review, and interview, the facility failed to follow a physician's medication order for 1 resident (#200) of 37 residents reviewed. The findings included: Review of the facility policy, Medication Record: Transcription of Doctors Orders and Documentation, date revised 4/16, revealed "...Transcribe Physician's written orders to MAR [medication administration record]...Dosage to be administered..." Medical record review revealed Resident #200 was admitted to the facility on 10/2/17 and discharged on10/9/17 with diagnoses including Anoxic Brain Damage, Epilepsy, Hyperlipidemia, and Dysphagia. Medical record review of Resident #200's Admission Orders dated 10/2/17 revealed "...Carbamazepine [seizure medication] 200 mg [milligram] CAP [capsule] two capsules by mouth twice a day [total of 400 mg twice a day]...Simvastatin [cholesterol medication] 40 mg TAB [tablet] take one-half tablet [total dose of 20 mg] by mouth at bedtime..." Review of the Medication Administration Record (MAR) dated 10/1/17 - 10/31/17 revealed "...Simvastatin Tablet 40 MG Give 1.5 tablet [total of 60 mg] by mouth at bedtime...CarBAMazepine Tablet 200 MG Give 200 mg by mouth two times a day..." Interview with the Director of Nursing (DON) on 10/25/17 at 3:46 PM, in the conference room, confirmed the Resident #200 had not received the medication as prescribed by the Physician's	F 309	**IDENTIFICATION** Director of Nursing reviewed 10 residents admissions orders on 10/26/17 to ensure there were no other errors and none were found. The Director of Nursing, Assistant Director and Unit Managers will review all resident's Plan of Service and EMARs to ensure all medications were administered as ordered by 11/30/2017. Any concerns will be addressed immediately, education provided and care plans updated as needed. **MEASURES'/SYSTEMIC CHANGES** The Nursing staff was in serviced on 11/8/17by Director of Nursing on the process of reviewing admission orders. Two nurses must review and initial all new and readmission orders for accuracy within 24 hours. The Director of Nursing or the Assistant Director of Nursing will then review admission and readmission orders for accuracy within 72 hours. .The Director of Nursing and Assistant Director of Nursing and Clinical Team (MDS and MDS Assessment Nurse) will audit all orders daily during morning clinical meeting to ensure accuracy. Any negative findings will be addressed, education provided and care plans updated as needed.	

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F 309	Continued From page 4 Orders. Continued interview confirmed the resident received the wrong dosage of 2 medications, and the facility's policy had not been followed.	F 309	**MONITOR/QA** The Director of Nursing will present findings of audits to the QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance, Social Services Director and other staff as appropriate) monthly for review and recommendations.	11/30/17
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure one resident (#129) was free from accident hazards of 37 sampled residents.	F 323	F323 The facility will ensure residents are free from accident hazards. **CORRECTIVE ACTIONS:** Lighter was removed from Resident #129 and room was checked by Social Services Director on 10/25/2017 to ensure there was no other smoking materials or safety hazards were present. None were found. **IDENTIFICATION** Rooms of residents that smoke were checked by Social Services Director and Interim Medical Records on 10/25/17 to ensure there were no smoking materials or safety hazards were present. All resident rooms and facility were inspected by Department Heads on 10/27/2017 to ensure no safety hazards were present. None were noted.	11/30/17

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F 323	Continued From page 5 The findings included: Review of the facility policy "Smoking Guidelines and Procedures" not dated, revealed "...all smoking materials...lighters...matches...are kept in a locked area for single distribution only..." Medical record review revealed Resident #129 was admitted to the facility on 5/31/17 with diagnoses including Paraplegia, Muscle Weakness, and Gastro-Esophageal Reflux Disease. Observation on 10/25/17 at 8:45 AM, in the residents room, revealed the wound nurse completing a dressing change on the resident. Continued observation revealed a lighter fell out of Resident #129's pocket when the wound nurse removed the resident's clothing to complete the dressing change. Interview with the Director of Nursing on 10/25/17 at 9:10 AM, in the conference room, confirmed the resident should not have had the lighter on his person, and the facility's policy for smoking materials had not been followed.	F 323	**MEASURES'/SYSTEMIC CHANGES** All Residents that smoke were educated on the smoking policy by the Social Services Director on 10/25/2017. All staff was educated by Director of Nursing by 10/27/2017 of accident/hazard. Department Heads, (Director of Nursing, Assistant Director of Nursing , MDS Coordinator, MDS Assessment Nurse, Dietary Manager, Activity Director, Social Services, Medical Records, Housekeeping Director and Admissions Director will systemically check rooms on a daily basis,5 days a week, to ensure that no smoking materials/safety hazards are present in resident rooms and facility. An audit will be completed by Department Heads. Daily 7 days a week for 4 weeks then weekly (5 days a week for 4 weeks, then monthly for 3 months on all residents that smoke in facility to ensure compliance. Any concerns will be addressed. Audits provided to Administrator for follow up with correction being made and education provided. **MONITOR/QA** The audits by Department heads will be given to the Director of Nursing/Administrator to present findings of these audits to the QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance, Social Services Director and other staff as appropriate) monthly for review and recommendations.	11/30/17